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W 000	INITIAL COMMENTS A recertification survey was conducted from May 28, 2008, through May 30, 2008, using the fundamental survey process. A random sample of three clients was selected from a residential population of six females with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews, and a review of records, including unusual incident reports.	W 000	Received on 6/20/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each entry into a client's record was signed and dated, for one of three clients (Client #1) included in the sample. The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #1's medical records on May 29, 2008, revealed the nursing personnel documented the annual nursing assessment and nursing quarterlies on the same form. Review of the document revealed specific sections where the nurse that performed the assessment (quarterly or annual) was to sign and date it after its completion. Closer review of the form failed to provide evidence that the annual assessment for Client #1 was signed and dated by the nurse that performed/completed the assessment. 2. The facility failed to ensure an investigation	W 114	W 114 1.In the future the RN Supervisor will ensure that all reports are reviewed for completion. See attached Annual Health Service Summary – signed and dated. 2. In the future all incidents will be presented to the Human Rights committee for review. All incidents occurring at the day program will also be presented and reviewed.	6/16/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gwan T. Sloan RN, BSN, MA	VP-Operations	6/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 114	Continued From page 1 involving Client #1 was dated. (See W156)	W 114		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure guardians were notified of serious incidents, for one of the three clients (Client #1) included in the sample. The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports, including available corresponding investigative reports, on May 28, 2008, beginning at 10:30 AM revealed the following: On November 20, 2007, day program staff reported noticing Client #1 crying "really hard." The client was observed to be seated next two other clients on a sofa. Staff documented that upon visual examination, Client #1's left pant leg, near her left thigh was wet. After closer examination of the area, staff revealed that a human bite mark was observed. Interview with the facility's QMRP on May 28, 2008 revealed Client #1 had a legal guardian. Continued review of the facility's incident report however, failed to provide evidence that the	W 148	W 148 Metro Homes, Inc. follows an Incident Management Policy and Procedure. The QMRP has been in serviced on Incident Management and Reporting. See attached In service record.	6/16/08

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W 148	Continued From page 2 client's legal guardian had been notified of the aforementioned incident.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensured the client's health and safety, for two of the three clients (Client #1 and #2) included in the sample. The finding includes: The facility failed to ensure the implementation of its "Incident Management" policy as outlined. A. Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports, including the available corresponding investigative reports, on May 28, 2008, beginning at 10:30 AM revealed the following: On November 20, 2007, day program staff reported noticing Client #1 crying "really hard." The client was observed to be seated next two other clients on a sofa. Staff documented that upon visual examination, Client #1's left pant leg, near her left thigh was wet. After closer examination of the area, staff revealed that a human bite mark was observed. Continued review of the facility's incident reports	W 149	W 149 a. refer to W 148 b. QMRP and Nursing staff were in serviced on Incident Management Policy and Procedure.	6/16/08

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W 149	Continued From page 3 failed to provide evidence that the aforementioned incident was reported immediately to the administrator or to other officials in accordance with State law. Additionally, the facility failed to provide evidence that the incident was thoroughly investigated. Interview with the QMRP and review of the facility's Incident Management Policy on May 29, 2008 revealed that incident involving Client #1 on November 20, 2007 would be classified as an allegation of abuse. According to the policy, allegations of abuse require notifications to be made to the Department of Health both verbally and via written documentation. At the time of the survey, the facility failed to ensure its Incident Management Policy was implemented. b. Client #2 was observed on May 29, 2008, at 10:35 AM arriving to her day program. The client was observed crying and she was not wearing any shoes or socks. The facility staff reported to the day program's receptionist that the client was not wearing any shoes or socks because her foot was hurting. The day program's nurse proceeded to examine the client's fifth toe on her left foot. Client #2 's toe was observed with a dark calloused area and it appeared to be sensitive to touch. After the client's examination, a day program staff contacted the facility in order to arrange for her to be picked up so that her toe could be further evaluated. Interview with the facility 's house manager on May 29, 2008 at 1:25 PM revealed that on Friday, May 23, 2008 she observed Client #2 crying in the facility. The house manager indicated that she did not know why the client was crying, but thought maybe the client's Ted Hose were too	W 149		

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W 149	Continued From page 4 tight. According to the house manager, after removing the client's Ted Hose she noticed that the client stopped crying. Further interview with the house manager revealed the facility's medication nurse was in the facility at that time, and was informed of the aforementioned concern. The house manager revealed that the medication nurse indicated that she would check the client's toe and contact the facility's nurse coordinator. However, there was no documented evidence that Client #2 was examined by the nurse. It should be noted that review of the facility's incident reports on May 28, 2008, failed to provide evicece that the incident was documented. Review of the "Incident Management" policy on May 28, 2008 at 11:00 AM revealed that the incidents were managed by the following listed steps: 1. The prompt reporting of all allegations or observations of incidents involving individuals. 2. Prompt staff interventions and generation of incident reports. 3. Prompt medical treatment or contact with community support personnel. 4. Timely and accurate verbal notification of appropriate staff, families or guardians, public officials and representatives from other agencies. 5. Investigation and documentation of incidents; 6. Personnel actions when warranted; 7. Review and corrective action to prevent the	W 149		

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W 149	Continued From page 5 recurrence of similar incidents; 8. Staff training in preventing, detecting, reporting and investigating incidents; and 9. Data collection and trending analysis as a means to develop preventative strategies and service plans for individuals to prevent more serious incidents from occurring. At the time of the survey, the facility failed to implement their Incident Management policy as recommended.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse were immediately reported to the administrator or to other officials in accordance with State law, for one of the three clients (Client #1) included the sample. The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports, including available corresponding investigative reports, on May 28, 2008, beginning at 10:30 AM revealed the	W 153	W 153 Refer to W 148	

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W 153	Continued From page 6 following: On November 20, 2007, day program staff reported noticing Client #1 crying "really hard." The client was observed to be seated next two other clients on a sofa. Staff documented that upon visual examination, Client #1's left pant leg, near her left thigh was wet. After closer examination of the area, staff revealed that a human bite mark was observed. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the administrator or to other officials in accordance with State law.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that allegations of abuse were thoroughly investigated, for one of the three clients (Client #1) included in the sample. The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports, including the available corresponding investigative reports, on May 28, 2008, beginning at 10:30 AM revealed the following: On November 20, 2007, day program staff reported noticing Client #1 crying "really hard." The client was observed to be seated next two	W 154	W 154 Refer to W 148, W149 b	

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W 154	Continued From page 7 other clients on a sofa. Staff documented that upon visual examination, Client #1's left pant leg, near her left thigh was wet. After closer examination of the area, staff revealed that a human bite mark was observed. Continued review of the incident report and corresponding investigative summary (not dated) revealed that Client #1 was seen by the day program nurse for evaluation. Review of the day program's inter-agency communication (dated November 20, 2007) revealed that there was an "imprint of teeth prominent in skin but there were no obvious breaks in the skin. Area cleansed with antibacterial soap and water. To be taken to ER for further evaluation and treatment." Further review of the communication revealed that the police and EMS arrived and determined that it was not necessary to transport the client to the emergency room due to the fact that Client #1's skin was still intact. Additional review of the incident report package and interview was conducted with the QMRP on May 28, 2008 to determine why the day program nurse requested emergency medical services. At the time of the survey, the reason why could not be determined. Furthermore, there was no evidence that investigative report identified the name of the perpetrator. Additionally, the investigation report failed to identify interviews conducted with all pertinent parties (i.e. the nurse that evaluated Client #1).	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law	W 156		

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W 156	Continued From page 8 within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure required investigations were reviewed by the administrator or designee within five working days, for one of the three clients (Clients #1) included in the sample. The finding includes: [Cross Refer to W154] Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports, including the available corresponding investigative reports, on May 28, 2008, beginning at 10:30 AM revealed an incident involving Client #1 dated November 20, 2007. According to the report, Client #1 was observed to have a human bite mark on her left thigh. Review of the corresponding investigative summary revealed the report was signed by the QMRP but was not dated. Additionally, there was no evidence the investigation was reviewed by the facility's administrator or designee.	W 156	W 156 Refer to W 148	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation	W 159	W 159 1. The QMRP has purchased new and appropriate fitting clothing for this client. 2. Staff were in serviced on the toileting program and the QMRP will monitor this program at least monthly to ensure it's completion.	

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W 159	Continued From page 9 Professional (QMRP). The findings include: 1. The QMRP failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. (See W189) 2. The QMRP failed to ensure that as soon as the Interdisciplinary Team (IDT) formulated each client' s Individual Program Plan (IPP), clients received continuous active treatment, consisting of needed interventions and services. (See W249) 3. The QMRP failed to provide evidence that Individual Program Plans (IPP)s were reviewed and revised once the client had successfully completed an objective, (See W255) 4. The QMRP failed to to ensure employees were effectively trained to provide foot care for Client #2. (See W192)	W 159	3. The ambulating program has been discontinued. In the future the QMRP will ensure that programs are reviewed at least monthly and appropriate revisions are made in a timely manner. 4. The staff were re-trained in foot care for the client. In the future the QMRP and Nursing staff will ensure that all Programs and In services are completed and on going to ensure staff are able to perform their duties effectively and efficiently.	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that each employee was provided with initial and continued training that enabled them to perform their duties effectively, efficiently, and competently.	W 189		

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W 189	Continued From page 10 The findings include: The facility failed to provide evidence that staff were effectively trained on assisting clients with dressing appropriately. Observation of Client #1 entering the facility on May 28, 2008 at 3:37 PM revealed the client was wearing yellow crop pants. The pants appeared to be made of a cotton-like material and fit closely to the client allowing her Adult Protective Undergarment (APU) to be seen. When staff were queried as to the fit of Client #1's pants and observation of her APU, staff immediately assisted the client to change her clothing. On May 30, 2008 at 12:20 PM, Client #1 was again observed to be wearing pants that fit closely. The impression of the client's APU was observed in the front of the client's pants and in the back. Interview with the staff revealed that the client had recently gained weight and many of her pants fit too closely. After the discussion with the staff member, Client #1 was escorted to her room and was assisted with changing her clothes. At the time of the survey, the facility failed to ensure staff were effectively trained to assist Client #1 with dressing appropriately in order to maintain levels of privacy.	W 189	W 189 Client has new clothing purchased. All staff were in serviced on Client Rights and Privacy.	6/16/08
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by:	W 192		

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W 192	Continued From page 11 Based on observation, interview and record review the facility failed to ensure employees were effectively trained to provide foot care, for one of the three clients (Client #2) included in the sample. The finding includes: Observation on May 30, 2008 at 4:00 PM revealed Client #2 sitting barefoot in her wheelchair. The client was observed with gauze between each of her toes. Interview with the facility's Registered Nurse (RN) on the aforementioned date revealed that she held an inservice training on May 29, 2008 at 3:00 PM. Continued interview with the RN revealed that the inservice was scheduled to train the direct care staff on proper foot care for Client #2. According to the RN, staff were trained to place cotton socks on Client #2's feet. Additionally, they were instructed to allow the client's feet to air out in order to promote healing. Review of Client #2's medical record revealed a nursing progress note dated May 29, 2008. The nursing progress note verified that the direct care staff had been inserviced on May 29, 2008 at 3:00 PM. The note also verified that the inservice agenda included proper foot care for Client #2. Additionally, the inservice addressed airing in between the client's toes and the use of cotton balls and/or gauze pads between her toes. Although Client #2 was observed with gauze between her toes, there was no evidence that she wore the cotton socks as recommended by the facility's RN. At the time of the survey, the facility failed to ensure staff were trained effectively to address Client #2's health needs.	W 192	W 192 Refer to W 159 – 4	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 12 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each client received continuous active treatment services, for one of the three clients (Client #1) included in the sample. The finding includes: Review of Client #1's records on May 29, 2008 at 10:50 AM revealed the client had an Individual Support Plan (ISP) dated December 18, 2007. Interview with the Qualified Mental Retardation Professional (QMRP) on May 29, 2008 and further review of Client #1's record revealed that at the time of the ISP meeting, the interdisciplinary team recommended program objectives including the following: Given verbal prompts, Client #1 will use the toilet appropriately 80% of the trials for three consecutive months. Further interview with the QMRP and review of the client's records failed to provide evidence that the aforementioned program objective had been implemented.	W 249	W 249 Refer to W159 - 2	
W 255	483.440(f)(1)(i) PROGRAM MONITORING &	W 255		

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W 255	Continued From page 13 CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to provide evidence that Individual Program Plans (IPP)s were reviewed and revised once the client had successfully completed an objective, for one of the three clients (Client #1) included in the sample. The finding includes: Review of Client #1's record on May 29, 2008 at 10:50 AM, revealed the client's Individual Support Plan (ISP) meeting was held on December 18, 2007. Interview with the QMRP and review of the client's corresponding IPP at 4:12 PM revealed the team recommended program objectives including the following for the current ISP year: - Given verbal cues, Client #1 will ambulate up and down stairs, 5 repetitions, 3 days per week for 12 consecutive months. - Given physical assistance, Client #1 will ambulate for 10 consecutive minutes, 3 days per week for 12 consecutive months. Interview with the QMRP and continued record	W 255	W 255 Refer to W 159 – 3	

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W 255	Continued From page 14 review on May 30, 2008 revealed Client #1 achieved the criteria for the aforementioned two program objectives prior to the ISP in December 2007. According to further interview and record review, the objectives were first introduced to Client #1 in 2006. At the time of the survey, the QMRP failed to ensure Client #1's program objectives were revised after the client achieved criteria.	W 255		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure timely general and preventative care services, for one of the three clients (Client #2) included in the sample. The findings include: I. The facility failed to ensure Client #2 received timely preventative care as evidenced below: Client #2 was observed on May 29, 2008, at 10:35 AM arriving to her day program. The day program staff was observed to immediately escort the client to the nurse's station. It should be noted that Client #2 was overheard crying. Continued observation revealed Client #2 was not wearing any shoes or socks. According to the day program staff, their receptionist was informed the client was not wearing any shoes or socks because her foot was hurting. The day program's nurse proceeded to examine the client's fifth toe on her left foot. The day program nurse's	W 322	W 322 In the future the facility QMRP and nursing staff will ensure that all clients' receive timely care and treatment. QMRP and nursing staff were in serviced on preventative care services.	6/16/08

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W 322	Continued From page 15 examination revealed that Client #2 's toe was observed with a dark calloused area and it appeared to be sensitive to touch. The nurse further observed Client #2 with a long red mark on her right leg that extended below her knee to the top of her foot. After the client's examination, a day program staff contacted the facility in order to arrange for her to be picked up so that her toe could be further evaluated. At 10:45 AM, the facility's staff arrived to pick-up Client #2. In route to the facility, the surveyor observed the facility's van parked at another day program. Client #2 was transported on that van and did not return to the facility for medical treatment until 1:12 PM.	W 322		

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R 000	INITIAL COMMENTS A re-licensure survey was conducted from May 28, 2008, through May 30, 2008. A random sample of three residents was selected from a residential population of six females with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews, and a review of records, including unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: Interview with the Director of Disability Services and review of the GHMRP's personnel records on May 28, 2008, at approximately 2:39 PM revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and	R 125	R 125 The agency has a policy and procedure on criminal background checks for new employees – prior to hiring and employment. Attached are the criminal background checks	6/16/08

Health Regulation Administration

Susan J. Sloan RPBSW, MA — VP. Operations — 6/18/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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R 125	Continued From page 1 worked for eight staff.	R 125		

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from May 28, 2008, through May 30, 2008. A random sample of three residents was selected from a residential population of six females with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews, and a review of records, including unusual incident reports.	I 000		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure each bathroom was equipped with a paper towel holder. The finding includes: Observations of the GHMRP' s environment and interview with the House Manager during the environmental walkthrough on May 29, 2008 at approximately 2:40 PM revealed there was no functional toilet paper holder in the bathroom located in the far bedroom. It should be noted that toilet paper was observed to be housed on the back of the toilet.	I 082	I 082 The toilet paper holder was replaced and staff were in serviced. In the future the QMRP and House Manager will ensure the environment is appropriately maintained.	6/16/08
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of	I 090		

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I 090	Continued From page 1 accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The findings include: Observation and interview with the House Manager during the environmental walkthrough on May 29, 2008 at approximately 2:40 PM revealed the following: Bathroom The sink in the bathroom located in the bedroom at the far end of the hall, leaked water from the faucet and the water temperature handles.	I 090	I 090 The bathroom faucet was fixed. In the future the QMRP and House Manager will ensure the environment is appropriately maintained.	6/16/08
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's	I 203	I 203 All employees receive an annual appraisal and sign a job description – initial and annually according to the Agency Policy. In the future the QMRP and the HR Department will ensure all employee records are updated according to policy. See attached job descriptions.	6/16/08

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I 203	Continued From page 2 personnel files on May 28, 2008 at 2:39 PM revealed the GHMRP failed to provide evidence that one direct care staff and two nurses had the contents of their job descriptions discussed with them at the beginning of their employment and/or annually thereafter.	I 203		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's personnel files on May 28, 2008 at 2:39 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for four staff and five consultants.	I 206	I 206 In the future the QMRP and the HR Department will ensure all employee records are updated according to policy. See attached health certificates.	6/16/08

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I 228	Continued From page 3	I 228		
I 228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident ' s rights; This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure staff were effectively trained in maintaining residents' privacy for three of the three residents (Resident #1, #2, and #3) in the facility. The finding includes: The facility failed to provide evidence that staff were effectively trained on assisting Residents with dressing appropriately. Observation of Resident #1 entering the facility on May 28, 2008 at 3:37 PM revealed the resident was wearing yellow crop pants. The pants appeared to be made of a cotton-like material and fit closely to the resident allowing her Adult Protective Undergarment (APU) to be seen. When staff were queried as to the fit of Resident #1's pants and observation of her APU, staff immediately assisted the Resident to change her clothing. On May 30, 2008 at 12:20 PM, Resident #1 was again observed to be wearing pants that fit closely. The impression of the resident's APU was observed in the front of the resident's pants and in the back. Interview with the staff revealed that the resident had recently gained weight and many of her pants fit too closely. After the discussion with the staff member, Resident #1 was escorted to her room and was assisted with	I 228	I 228 Refer to W 189	

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I 228	Continued From page 4 changing her clothes. At the time of the survey, the facility failed to ensure staff were effectively trained to assist Resident #1 with dressing appropriately in order to maintain levels of privacy. (See Federal Deficiency Report Citation W189)	I 228		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that after medical services were secured, prompt notification of unusual incidents was made to the resident' s guardian, followed by written notice and documentation of the resident's status no later than forty-eight (48) hours after the incident, for one of the three residents (Resident #1) included in the sample. The findings include: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports, including available corresponding investigative reports, on May 28, 2008, beginning at 10:30 AM revealed the following:	I 374	I 374 Refer to W 148	

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I 374	Continued From page 5 On November 20, 2007, day program staff reported noticing Resident #1 crying "really hard." The resident was observed to be seated next two other residents on a sofa. Staff documented that upon visual examination, Resident #1's left pant leg, near her left thigh was wet. After closer examination of the area, staff revealed that a human bite mark was observed. Interview with the facility's QMRP on May 28, 2008 revealed Resident #1 had a legal guardian. Continued review of the facility's incident report however, failed to provide evidence that the resident's legal guardian had been notified of the aforementioned incident.	I 374		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was notified as required (both immediately notified and followed by written notification within 24 hours), of unusual incidents that substantially interfered with a resident's health, for two of the three residents (Residents #1 and #2) included in the sample.	I 379	I 379 1.&2. Refer to W 148	

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I 379	Continued From page 6 The findings include: 1. Interview with the facility 's house manager on May 29, 2008 at 1:25 PM revealed that on Friday, May 23, 2008 she observed Client #2 crying. The house manager indicated that she did not know why the client was crying, but thought maybe her Ted Hose was too tight. According to the house manager she proceeded to take the client's Ted Hose off and indicated that the client stopped crying. Further interview with the house manager revealed the facility's medication nurse was in the facility at that time, and was informed of the afforementioned concern. Continued interview with the house manager revealed that she asked the medication nurse to examine the client. According to the house manager the medication nurse indicated that she would check the client's toe and contact the facility's nurse coordinator. The house manager said she made sure that the staff was aware that Client #2's toe had been bothering her and to make sure that they monitored her toe. Continued interview with the house manager on May 30, 2008 at 12:46 PM, revealed that she observed a fungus on Client #2's foot on Friday, May 23, 2008. Continued interview with the house manager revealed a direct care staff contacted her on Saturday, May 24, 2008 to report that something was wrong with Client #2's toe. The house manager indicated that she instructed the staff to be sure to document her observation and to inform the medication nurse when she comes to administer medications. Review of the facility's incident reports on May 28, 2008 at 10:26 AM failed to evidence the aforementioned incident had been reported to the	I 379		

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I 379	Continued From page 7 Department of Health immediately and followed by written notification within 24 hours as required. 2. Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports, including available corresponding investigative reports, on May 28, 2008, beginning at 10:30 AM revealed the following: On November 20, 2007, day program staff reported noticing Resident #1 crying "really hard." The resident was observed to be seated next two other residents on a sofa. Staff documented that upon visual examination, Resident #1's left pant leg, near her left thigh was wet. After closer examination of the area, staff revealed that a human bite mark was observed. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the Department of Health as required.	I 379		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s), for one of the three residents (Resident #1) included in the sample. The finding includes: Review of Resident #1's records on May 29, 2008	I 422	I 422 Refer to W159-2	

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I 422	Continued From page 8 at 10:50 AM revealed the resident had an Individual Support Plan (ISP) dated December 18, 2007. Interview with the Qualified Mental Retardation Professional (QMRP) on May 29, 2008 and further review of Resident #1's record revealed that at the time of the ISP meeting, the interdisciplinary team recommended program objectives including the following: Given verbal prompts, Resident #1 will use the toilet appropriately 80% of the trials for three consecutive months. Further interview with the QMRP and review of the resident's records failed to provide evidence that the aforementioned program objective had been implemented. (See also Federal Deficiency Report Citation W249)	I 422		
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure program revisions were made at least every six months or when a resident successfully completed the objective, for one of the three residents (Resident #1) included in the sample. The finding includes:	I 424	I 424 Refer to W 255	

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I 424	Continued From page 9 Review of Resident #1's record on May 29, 2008 at 10:50 AM, revealed the resident's Individual Support Plan (ISP) meeting was held on December 18, 2007. Interview with the QMRP and review of the resident's corresponding IPP at 4:12 PM revealed the team recommended program objectives including the following for the current ISP year: - Given verbal cues, Resident #1 will ambulate up and down stairs, 5 repetitions, 3 days per week for 12 consecutive months. - Given physical assistance, Resident #1 will ambulate for 10 consecutive minutes, 3 days per week for 12 consecutive months. Interview with the QMRP and continued record review on May 30, 2008 revealed Resident #1 achieved the criteria for the aforementioned two program objectives prior to the ISP in December 2007. According to further interview and record review, the objectives were first introduced to Resident #1 in 2006. At the time of the survey, the QMRP failed to ensure Resident #1's program objectives were revised after the Resident achieved criteria. (See Federal Deficiency Report Citation W255)	I 424		